**CARE TRANSFORMATION COLLABORATIVE (CTC)**

**COLLABORATIVE AGREEMENT SCOPE OF SERVICE/WORK**

**Consisting of 4 pages**

**Pediatric Primary Care Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Assigned to Pediatric IBH Cohort: \_\_\_\_\_\_**

1. Introduction/Purpose

The Care Transformation Collaborative of Rhode Island (CTC-RI) and PCMH Kids, with funding from the Rhode Island Foundation Behavioral Health Fund, Tufts Health Plan and UnitedHealthcare, is providing IBH practice facilitation and practice infrastructure support for 9 pediatric primary care practices (pediatrics or family medicine) over a two-year time period. There will be two IBH cohorts, servicing an anticipated combined attributed patient population of approximately 30,000 children and adolescents.

Strategic Goals:

CTC/PCMH Kids: To develop, implement and evaluate a sustainable IBH model serving children, adolescent and postpartum moms within primary care settings.

Rhode Island Behavioral Health Fund: To address behavioral health (mental health and substance use) needs *before* people are in crisis.

Pediatric Integrated Behavioral Health Objectives:

1. To increase the identification, early intervention, and treatment of behavioral health challenges before children, adolescents and families reach crisis by implementing developmentally appropriate behavioral guidance, evidence-based screening guidelines, tools and treatment models for different populations of focus;
2. To increase ready access to brief behavioral health intervention for patients with behavioral health conditions by hiring and integrating an on-site behavioral health clinician (based on size of the practice but no less than 0.5 FTE licensed behavioral health clinician);
3. To provide care coordination for children, adolescents and families by developing a robust relationship with a community partner based on an identified population health behavioral health need;
4. To improve performance by implementing two performance improvement studies, participating in quarterly learning network meetings and having practice team members participate in monthly planning meetings that are facilitated by the pediatric IBH practice facilitator.
5. Services to Be Provided/Practice Requirements

Primary care patients and practices would benefit from having ready access to on-site behavioral health services and a coordinated referral system to specialty behavioral health services when patient severity requires higher levels of care and coordination. Practices that participate in the Pediatric IBH business model will contribute to create a sustainable pediatric primary care program that provides children and families with ready access to behavioral health care and assists systems of care with managing risk-based contracts.

Assumptions:

* Primary care practices, through the IBH model, will be able to provide on-site behavioral health treatment for twenty to thirty percent of the patient population that is seen each year in the PCP setting;
* Primary care practices will pre-schedule monthly on-site IBH consultation with system of care (SOC) representation (based on area of focus: i.e. billing, IT enhancements, hiring and credentialing) during the first three months of “ramp up”; With change in circumstances, practices would be expected to re-schedule monthly meetings in order to maintain focus on meeting program objectives, within the same month;
* Systems of care will provide practices with IT support needed to effectively capture and report behavioral health and health related social determinant of health screening and interventions, coding and behavioral health information to successfully bill for behavioral health services in primary care and human resources support to hire and credential behavioral health provider.

Practice Requirements:

Cohort 1 practices are assigned to participate from July 2019 to June 2021 with expectation that practice will participate in July 2019 Orientation Program, participate in quarterly learning network meetings starting in October 2019 through March 2022 and collect and submit data through March 2022.

Cohort 2 practices are assigned to participate from April 2020 to March 2022 with expectation that practice will participate in July 2019 Orientation Program, participate in quarterly learning network meetings starting in October 2019 through March 2022 and collect and submit data starting in May 2020 through March 2022.

IBH Start-Up (Year 1):

* Participate in Orientation Program and quarterly participation in quarterly webinar/live learning events;
* Identity team membership (to include provider champion, nurse care manager/care coordinator, behavioral health clinician (if hired) and practice/office manager; host monthly on-site IBH practice facilitation-initial meeting within 30-45 days of start of program;
* Develop a staffing plan for patients to be able to access BH assessment/treatment with same day to 48-hour access and post behavioral health clinician position if not already in place within 2 months;
* Select three out of five populations of focus and identify mechanisms within the electronic health record for being able to capture and report screening rates and provide baseline within 2 months;
* Establish billing systems that will allow for the billing of BH services and/or establish supervision of BH interns (within three (3) months of start date of IBH clinician or award notification if IBH clinician already hired);
* Hire behavioral health (BH) staff if not already in place with a staffing ratio between 0.5-1.0 FTE’ s depending on practice size with staff ready to see patients within 4 (four) months of award notification; **Note**: Practice may hire clinician and have a latter start date to allow time for the credentialing process; health plans have 45 days to process credentialing applications from the time a complete application is received.
* Establish IBH workflows including roles and responsibilities for screening protocols, implementing warm hand-offs and care coordination of referrals when external behavioral health resources are needed (within six (6) months of award notification);
* Implement program identified evidence-based screening tools for 3 out of 5 populations of focus within six (6) months of award notification and provide quarterly reports;
* Submit an AIM statement and performance improvement (PI) plan for improving screening rates within nine (9) months (or other relevant PI study if practice is meeting screening thresholds for three of the selected populations of focus);
* Complete [Maine Health Access Evaluation Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) at completion of the one year.

IBH Performance Year (Year 2):

* Execute Memorandum of Agreement with PEDI PRN (if not already in place) and MOMS PRN (if available) within month 1;
* Submit an updated performance improvement outcome plan for increasing screening rates by month three (3) (or other relevant PI study if already meeting screening thresholds);
* Demonstrate use of registry report which provides information on initial screening results for selected behavioral health condition and follow up screening result post intervention by month four (4);
* Submit an AIM statement performance improvement (PI) plan for addressing a population health need that can be addressed through improved connections to community resources by month six (6);
* Submit an updated AIM statement and performance improvement (PI) outcome based on implementing the community resource intervention by month twelve (12);
* Complete [Maine Health Access Evaluation Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) at completion of the year 2.
* Continue to meet monthly with on-site IBH practice facilitator, attend quarterly learning network meetings and submit quarterly screening results.
* Participate in interview process as part of the qualitative research study.

Practice Compensation:

Practices will be eligible to receive

1. Infrastructure payment of $18,000, in two installments, that practices can use to off-set costs associated with on boarding behavioral health clinician, developing coding and billing mechanisms needed for sustainability and costs associated with non-billable time.
2. Eligibility for up to $10,000 in incentive payments based on meeting service delivery requirements and screening rate thresholds;
3. Two years of monthly on-site consultation from a trained Pediatric Integrated Behavioral Health Practice Facilitator;
4. Quarterly learning collaborative with content experts and best practice sharing from other practices participating in IBH initiative;
5. Data management support in evaluating outcomes and utilization.

Practices would select, implement and report on three out of five standardized evidence-based screening measures based on the populations of focus most relevant to the practice site. CTC will provide practices with measurement specifications that practices will apply when reporting screening outcomes. Payment will be prorated based on percentage of targets met. CTC will make incentive payment to the practice at the end of Start-up Year (Year 1) and the end of Performance Year (Year 2). CTC reserves the right to delay/withhold payments if Practice fails to meet any of the practice requirements.

Populations of Focus:

1) Depression: PHQ-A(adolescent)

2) Anxiety: GAD-7 (adolescent)

3) Substance use: CRAFFT or CAGE-AID (adolescent)

4) Middle childhood: Pediatric Symptom Checklist

5) Postpartum depression: Edinburgh Postnatal Depression Scale.

Screening Rate Thresholds

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Depression | Anxiety | Substance use | Middle childhood  | Postpartum screening  |
| **End of Startup (Year 1)** | 60% | 40% | 40% | 40% | 40% |
| **End of Performance Year (Year 2)** | 75% | 60% | 60% | 60% | 60% |

Care Transformation Collaborative of RI Primary Care Practice name.



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Signature: Debra Hurwitz, Signature of authorized staff

Executive Director, CTC-RI

ATTACHMENT B: IBH MILESTONES SUMMARY DOCUMENT

ATTACHMENT C: IBH MEASUREMENT SPECIFICATIONS